Fatal child abuse: a study of 13 cases of continuous abuse

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Abstract

A parent who continuously physically abuses her/his child doesn't aim to kill the child but commits an accidental filicide in a more violent outburst of anger. Fatal abuse deaths are prevented by recognition of signs of battering in time. Out of 200 examined intra-familial filicides, 23 (12%) were caused by child battering and 13 (7%) by continuous battering. The medical and court records of the victim and the perpetrator were examined. The perpetrator was the biological mother and the victim was male in 69 per cent of the cases. The abused children were either younger than one year or from two-and-a-half to four years old. Risk factors of the victim (being unwanted, premature birth, separation from the parent caused by hospitalization or custodial care, being ill and crying a lot) and the perpetrator (personality disorder, low socioeconomic status, chaotic family conditions, domestic violence, isolation, alcohol abuse) were common. The injuries caused by previous battering were mostly soft tissue injuries in head and limbs and head traumas and the battering lasted for days or even an year. The final assault was more violent and occurred when the parent was more anxious, frustrated or left alone with the child. The perpetrating parent was diagnosed as having a personality disorder (borderline, narcissistic or dependent) and often substance dependence (31%). None of them were psychotic. Authorities and community members should pay attention to the change in child's behavior and inexplicable injuries or absence from daycare. Furthermore if the parent is immature, alcohol dependent, have a personality disorder and is unable to cope with the demands the small child entails in the parent's life, the child may be in danger.

Introduction

Child homicides, filicides, are often committed in context of psychosis,[1-3] mood disorder, suicide or abuse.[4-6] Acute psychotic filicides involves severely mentally ill parents who kill the child without a comprehensive motive, in a state of mental psychosis. Altruistic filicides are committed with the motive of relieving the child of real or most often imaginary suffering, and usually involve a suicide attempt by the parent. In neonaticides, the unwanted child filicide category, the perpetrator often conceals the pregnancy and gives the birth and kills the child in secrecy.

Spousal revenge filicide occurs when the perpetrator kills the child specifically to emotionally harm child's other parent.[7,8]

Fatal abuse filicide indicates battering or physical abuse, which causes the death of the child. The filicide is unintentional, accidental and due to single or recurring battering.[7-9] The child is often a victim of multiple nonfatal episodes of abuse as disciplinary reasons.[10] Often there is a continuum of violence from mild and infrequent to severe and frequent.[7,11] Prior to the fatality the perpetrator often gives warning signals to professionals and members of their personal network by alerting them to the abusive incidents.[8] Previous abuse has been confirmed in many studies.[8,12-17] Henry Kempe,[11] who originally coined the term battered child syndrome, assumed the battering to escalate and cause the death of the battered child in 11% of the cases. Children reported to service agencies for suspected child abuse have even a three-fold greater risk of death.[18] Child maltreatment and neglect exists with child abuse but maltreatment itself is seldom coded but has been detected even in 40% of the child homicides.[19] The true incidence of fatal abuse and neglect is unknown as inflicted injuries are sometimes misdiagnosed as unintentional accidents or caused by a Sudden Infant Death Syndrome.[20,21]

The fatal abuse is associated with prematurity, developmental disorders, health problems of the child and the victim has often been neglected and separated from the parent after the birth[12,22] unlike filicide victims from other categories. The victim is also often the first-born and in many cases the only child of the family.[23,24] The assault happens often in a situation when the child is crying and the perpetrator is alone with the child.[24]

Abusive perpetrators are defined as young, immature, uneducated and have violent and chaotic backgrounds. Personality disorder, has been found to be common diagnosis.[25-27]

Despite the fact that the diagnosed personality disorder may diminish the responsibility, the child abuse perpetrators are convicted with long sentences.[28-29]

This study is a part of series of investigations of retrospective, register-based research of intra-familial child filicides in Finland during 25 years. The aims of this part of the study are to investigate a sample of 13 cases, where the signs of recurrent battering of the victims were detected. The study describes demographic data of the parent and the victim, the health of the victim, the mental health of the perpetrator, as well as the signs of battering and discusses the factors increasing the risk for battering and the fatal abuse.

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Materials and Methods

The sample, ethical approval and methods are presented in our previous publications.[27,30,31].

In the sample of 65 filicides studied more thoroughly, the data was obtained from medical forensic, police and court records, which included forensic psychiatric examination when required by the court. All the victims were killed as a result of parent's violence. In most cases the aim of the perpetrator was to kill the child or children of psychotic, altruistic or suicidal intentions unlike in 23 cases, where the filicide was caused by battering. The death was *accidental* and was caused by a single or recurrent aggressive outburst to keep the child calm or to make him/her obey the parent. In 13 cases the battering occurred twice or was recurrent and a continuum of separate episodes of battering. Data were examined with descriptive statistics using SSPS-statistics (means, standard deviation, 95% confident interval, and the percentage for categorical variables.); however because of the small sample size, statistical tests of significance were frequently not feasible.

Results

Nine of the thirteen perpetrating parents were biological mothers (69%), three biological fathers (23%), and one a stepfather (8%). The mean age of the perpetrators was 26,1 years (SD 6.4, CL95% 22.3-30.0). In two cases both parents repeatedly battered the child, but the mother caused the death (cases 7 and 9 in Table 1). The perpetrators were married or cohabiting except one single mother (case 6) and one divorced mother (case 8). The other parent was non-biological father in two cases and both stepfathers battered the child constantly (cases 9 and 13). Almost all perpetrators, especially mothers, had a low socioeconomic status (except in the case 4), and 70 percent of them lived in urban areas. The victim was female in four (31%) and male in nine (69%) and cases. Maternal perpetrators killed six male and three female children, and paternal perpetrators killed three male and one female children. The victims were either younger than 1 year (46%) or from 2 1/2 to 4 years old in 46 percent of cases. The mean age of the victims was 1.6 years (SD 1.4, Cl95% 0.8-2.5). Eight victims were the firstborn and five were the second of the family's two children. Three children were born prematurely (cases 3, 5, 11), two had a physical illness (cases 5, 11) and one child was diagnosed as developmentally retarded (case 10). Two of the victims had been taken into care but were returned to the biological parent/s only a few months before the fatal assault (cases 7, 9). Five children (38%) had been separated from the perpetrator by hospitalization or custodial care from the birth or not being a biological parent (cases 5, 7, 9, 11, 13). The parents abused the child when trying to keep the crying infant calm (cases 1-6) or when trying ensure the child's obedience (cases 9-13) . Often there was no evidence of the bad behavior by the child, and the overly demanding parent interpreted the child's developmental skills and behavior as a sign of disobedience or the child looking at the parent as criticism or complaint. Stress caused by the demands placed on the parent when taking care of the child, lack of social support, an unstable mental state were evident in most cases.

The examined perpetrators were diagnosed with a personality disorder in over 90% of cases, mostly borderline, narcissistic, dependent or immature personalities with difficulties in controlling affects. Two perpetrators had IQ under 85 and one parent 87. Two perpetrators were diagnosed having non-psychotic depression and none of the perpetrators were psychotic unlike in the rest of the examined cases. Thirty-eight percent abused alcohol and were even intoxicated during the fatal assault (cases 3 and 5). The perpetrator was a victim or a perpetrator of domestic violence in 46% of cases (cases 3,5,7,8,11,13). The most common injuries from previous battering were skin and soft tissue traumas caused by the parent hitting the child with a fist, a stick, a belt and head traumas caused by throwing the child against a doorframe, a wall or a floor. Often the child had numerous bruises and cuts all over the body caused by the frequent battering. In nine cases the injuries of the previous battering were very serious, causing head traumas and fractures. However, the less critical injuring was long lasting, cruel and recurrent hitting of the child of *disciplinary* reasons (cases 8, 9, 12, 13).

Only two perpetrators gave warning signals and some perpetrators even became even more isolated preceding the fatal assault.

The demographic data of the victims and perpetrators, short case description, previous and fatal injuries, diagnosis, responsibility and sentence of the perpetrator are presented in Table 1. In six cases the other parent knew about the abuse of the child (cases 3, 5, 7, 9, 10, 12). The daycare authorities had noticed the bruises and the loss of hair in two cases (cases 8, 11) but believed the parent's explanations, and not even clear signs of abuse were examined. Social workers and public health nurses visited the home of one child several times and noted the change in the child's behavior, but did not act in time (case 13). Two mothers who had a newborn infant, battered the child within few days. Their mental state deteriorated rapidly but they were not psychotic (cases 1 and 2). During the fatal assault medical help was often late in arriving since the parent was reluctant to take the child to the hospital as the bruises and scars could be easily have been detected as intentionally inflicted injuries.

Eleven perpetrators were given sentences from 6 months to a life sentence (Mean 5 years 8 months). One mother, whose responsibility was not examined was on probation and one mother was pronounced not responsible for her actions and not sentenced.

The following cases illustrate the pathways to filicide, how rapidly the violence can escalate and turn fatal. These cases demonstrate also the impact of domestic violence and the over generational transmission of violence.

Patient #13

Neighbors and visitors had called the public health nurse and social service officials several times about their concern for the safety of a four-year-old boy who lived with his mother and stepfather in a small village. The family had moved to the area some months earlier and the nurse and the health center doctor had seen the family twice and pronounced the child healthy. Following the neighbors' calls the nurse made a house call and noted that in four months the child's behavior had changed; the child was frightened and did not play in the same way as during the previous visit. The mother denied having any difficulties or worries about her son or the stepfather. Local social services officials had visited the family once prior to the neighbors' concern for the child's well being. During a later house call they failed to notice any matters of concern, like bruises on the child, whom they met briefly in the entryway dressed in winter clothing. The parents denied having any problems with their son. The social service officials contacted the public health nurse, who promised to make another house call. During the next visit the four-year-old boy was standing stiffly beside his bed. The nurse took him on her lap and the child sat there for one-and-a-half hours holding his head against the nurse's shoulder. The nurse viewed this behavior as a call for protection. She called the social services officials and conveyed her concern about the child's behavior. Three days later, the boy died after the stepfather had battered him. The cause of death was a subdural hemorrhage causing odema and aspiration of vomit. The autopsy showed over 20 bruises and several scars were found on his body. The bruises and scars were caused by separate incidents of battering over days and months. The mother reported to the police that both she and her child had been victims of domestic violence several times during the previous months. The stepfather had beaten the child with a belt, kicked him, pulled his hair, squeezed him, thrown him down and threatened him with a knife. The boy had started wetting his bed, which was a further excuse for physical abuse. The fatal battering occurred after a bedwetting incident and the stepfather beat the child's head against the floor. The child climbed into his bed and became unconscious. The stepfather did not permit the mother to call for help and the child died during the night.

The mental examination was not required but the perpetrator was sentenced 6 years 2 months for severe abuse and manslaughter. The perpetrator claimed in the investigations that he suspected others to think that he cannot take care of the family and that they will encourage the wife to divorce him. The actions taken by the authorities made him even more anxious and increased his outbursts of violence.

Patient #4

The public health nurse was worried about a 2½-month-old male child who, in addition to colic symptoms, was very sensitive to touching and handling. The baby was sent to the children's hospital where no injuries or signs of disease were found. Ultrasound and x-ray investigations were performed. Later, at the age of 3½ months, additional examinations including further x-rays were made. Only a slight suspicion of rachitis was mentioned in

Table 1. Patients' data.

#	Victim Age	Perpetrator Age	Short case descriptions	Previous battering	Injuries * final cause of death	Diagnoses Responsibility Sentence
1	Male 13 days	Mother 24 years	The mother impatient, tired and could not cope with the crying baby and the one year old sibling. The mother didn't want to be left alone with the baby and left the baby alone during the day. The mother hit the crying child several times when taking care and threw him against the sofa.	Mother hit the baby's face with her fist	Skull fracture, Bruising * Intra-cranial hemorrhage	Depression PD; Borderline Diminished responsibility 6 months
2	Female 24 days	Mother 21 years	The mother was stressed by family duties and was helpless with the baby. When she was left alone with the baby, she hit the baby's head against a doorframe, dropped her and pressed the head with her knee.	Hitting and shaking, dropping the baby, pressing the head.	Skull fractures, cerebral contusion, bruises * Intra-cranial hemorrhage	No mental Examination On probation
3	Male 2 months	Father 34 years	The father abused alcohol and drugs. Previous hospitalization due to falling from the parent's lap. Battering occurred in unclear circumstances when the mother was absent.	Hitting the baby's head against hard objects several times	Skull fracture with a blunt obstacle and intra-cranial hemorrhage * Skull fracture with a sharp obstacle; edema	PD; Dependent, paranoid, alcohol dependence Dimin. Responsibi. 10 years
4	Male 4 months	Father 25 years	The child was crying more after turning 2 months. Several visits to health care center. The child was extremely sensitive to touching and handling especially when in father's arms. When left alone with the baby the father battered the child compulsively by pressing and punching the baby's body.	Punching and pressing the head and body	Several bone fractures in the skull, wrist, ribs, hips * Skull fracture Intra-cranial hemorrhage	PD; Dependent, Immature Diminished responsibility 4 years
5	Male 6 months	Mother 32 years	The child unwanted, premature, had a congenital heart defects and was hospitalized for 3 first months. Mother alcoholic, father violent. Three older siblings taken into custodial care. Mother battered the child by biting, hitting and beating against hard material to keep the baby calm and quiet.	Hitting, biting, strangling, beating the head against the wall	Skull fracture, Intra-cranial hemorrhage; Bruises, cuts; malnutrition * Several intra-cranial hemorrhage; edema	PD; Borderline, alcohol dependence Diminished responsibility 5 years 6m
6	Male 8 months	Mother 20 years	The mother withdrawn and anxious. Lived with her parents and was afraid they would think she is not good enough. The mother shook and smothered when the baby cried	Smothering Shaking the baby against the floor	Cerebral Contusion * Intra-cranial hemorrhage	PD; Schizoid Diminished Responsibility One year
7	Female 16 months	Mother 22 years	Unwanted pregnancy, the child was taken into custodial care and later returned due to economic benefits. The father was unstable and violent and battered the victim for a longer period, the mother strangled the unconscious child	Letting the child fall, causing accidents and burns	Intra-cranial hemorrhage Bruises in facial area; Large burn in the back * Mechanical asphyxia caused by strangulation	No dg. Histrionic and narcissistic features./ IQ IQ 77 Responsible Life sentence
8	Male 2½ years	Mother 42 years	The mother was divorced from the violent father, She was depressed, abused alcohol, jealous about the son and disappeared sometimes with the son. Signs of battering detected in daycare during two months.	Bruises, loss of hair and a change in child's behavior	* Asphyxia caused by strangulation	Depression PD; Narcissistic Alc.dep./ IQ 87 Not Resp. No sentence
9	Male 2 ½ years	Mother 21 years	The child was taken into custodial care and lived in a swedish speaking family and was returned to the finnish speaking mother 4 months prior to death. The child's behavior was seen as disobedience and the stepfather constantly battered the child. The mother pushing the child down caused the death.	Hitting the child with a belt, pushing the child to the floor frequently	Bruises all over the body and the head * Intra-cranial hemorrhage	PD; Schizoid IQ 70 Diminished responsibility 3 years
10	Female 3 years	Father 29 years	Pregnancy concealed, the victim and her mother mentally retarded. The family was supported by authorities and the family for 2 ½ years. The battering started when the parents got an own apartment and the support decreased.	Hitting with a belt seven times, pushing and throwing the child down	Skull fracture, intra-cranial hemorrhage Bruises all over the body * Pneumonia	PD; Borderline, autistic features Diminished responsibility 8 years 10 m
11	Female 3 years	Mother 22 years	Child born prematurely, often ill. Mother was mentally unbalanced, having anorexia and being jealous. Battering during two years by kicking and hitting, when the mother felt the child as an obstacle or criticizing her. Fatal battering over a period of a few days.	Hitting, kicking, biting, 2 years. Bruises detected In daycare	Interstitial wounds in the brain and the lungs; bruises on the head and the body * Laceration of the liver	PD; Borderline, anorexia nervosa Diminished responsibility 2 years 6months
12	Male 3 years	Mother 26 years	Older sibling taken into custodial care because of battering. Mother's psychotherapy ceased and after that the battering started. The mother let no one take care of the child, not even the father. The mother battered 3 times a week during one year, when the child could not cope with the mother's high demands.	Beating with a wooden stick	Scars, cuts and bruises in the head and the back * Asphyxia caused by aspiration of vomit	PD; Borderline, paranoid, alcohol dependence Responsible 8 years 6m
13	Male 4 years	Stepfather 22 years	Unwanted pregnancy. New marriage, domestic violence and constant battering of the victim. Several house calls by authorities: change in the child's behavior detected. The child was seeking comfort from the authorities. The stepfather got more anxious and the battering escalated.	Hitting, kicking, pulling Threatening with a knife	Several bruises, cuts, and scars; loss of hair * Intra-cranial hemorrhage; Asphyxia caused by vomit	No mental examination – 6 years

Dg, Diagnoses in Mental examination; PD, Personality disorder; IQ, Intelligence quotient.

the hospital records. At the age of 4½ months the child was brought to the hospital and after resuscitation he died five hours later. In the autopsy several injuries were found. A recent fracture of the skull and a subdural hemorrhage and a diffuse contusion of the brain were noted as the causes of death. Furthermore, a pelvic fracture, a hemorrhage in the medullar canal in the lumbar area and several hemorrhages in the scalp were found. Old injuries in different phases of healing included subdural hemorrhages, several rib fractures and a fracture of the right radius. A re-examination of the x-rays taken two months earlier indicated visible fractures of several ribs; they had previously gone unnoticed.

After a lengthy interrogation the child's father admitted that he had hit and squeezed the baby several times over the course of months. He claimed, however, that the injuries that caused the child's death were due to an accidental fall. He had obsessional need to batter the baby, when ever left alone with the baby and when he felt helpless. The mother had noticed that the baby's cry turned more tense, when the father hold him. However she had no suspicion of the battering since the father was very caring and worried about the well-being of the baby.

In the mental examination the father was diagnosed as having a personality disorder; dependent personality with psychotic features, lack of empathy, repressed anger and no emotional contact to his childhood experiences. His intelligence was above the average.

In the perpetrator's childhood, his father abused alcohol and was unpredictable. When he was drunk during the weekends, he was very violent towards his wife and threatened to kill her. He also was suicidal and told stories about a father who killed his children.

Discussion

Although fatal child abuse is a rare even and more like a top of an ice-berg among the dangerous conditions many children are living in, many of these deaths could have been prevented. The Arizona Child Fatality study claims that 61% of child abuse deaths were considered to be preventable and much of the responsibility for prevention rests with community members (relatives and neighbors), who are aware of the abuse, but failed to report the family to social services.[32] Almost half of the other parents in this study knew about the battering but often the violent behavior of the family members and domestic violence hindered the other parent to put an end to the abuse. The parents and families were often isolated and out of reach of the authorities, especially medical expertise.

The injuries were seen in daycare or by other authorities but they failed to act in time. The signs of battering were inexplicable injuries or a change in the child's behavior, for example, depression, withdrawal, anxiety or the irritability of the baby or being absent from daycare.

The most common previous injuries were in skin and soft tissue[33] and the fatal injury was a head trauma.[34] After the fatal battering, the parents did not dare to take the unconscious child to the hospital as signs of the inflicted injuries could be seen. None of the parents wanted to kill the child intentionally. The more fatal violence escalated rapidly in most of the cases even when the continuous battering had lasted months or even two years.

When compared with the other filicide cases in the sample the victims were younger and more often born unwanted. The relationship and attachment with the child could have been affected by the separation from the parent. It was caused by the prematurity and hospitalization of the child as seen in three cases or the child being in care since birth as was the case in two cases. The parents who were separated from the child did not seem to have the biological need to protect the child nor did they seem to be attached to the child. These parents, as well as the stepfathers had too high demands for the child and often the battering abuse started when the child failed to stand-alone with dressing up, eating etc. or the small child wed his/her bed.

IIn the two cases, numbered 7 and 9, the battering was causing exceptional suffering for the child, since both the parents were battering the child. In both cases the father was very violent and the IQ of the mother was under 85. The child had been taken in custody and returned to the parents only few months earlier. The parents' motive to get the child back home was to get economical benefits.

The first two cases involved an infant and a very tired mother who was inpatient and angry. The first mother had an older child who was only one year old and either child was sleeping well. The other was very disappointed and angry at his husband. The situation deteriorated rapidly but could have been prevented with the help in nursing the babies.

Almost all perpetrators were diagnosed as having a personality disorder; borderline, narcissistic, dependent or immaturity. All perpetrators had difficulties in controlling their affects and anger. None of the perpetrators were psychotic and only two were diagnosed depressed unlike in the main sample of filicides other than fatal abuse cases.

Personality disorder was an important construct in explaining the poor parenting of the perpetrator. Egocentricity and impulsivity, lack of empathy and remorse, as well as shallow and labile affects are typical personality traits found with abusive perpetrators.[26] These features could be detected in the interviews of these perpetrators. Poor marital relationships, domestic violence, isolation and alcohol abuse deteriorated even more the parents' capability to cope with the stressful situations with the child.

The sample of 13 cases is small and does not allow any statistical comparison nor we cannot exclude previous battering in the corpus material, because battering does not leave permanent injuries and the disclosure of the battering may impair a parent's situation in legal proceedings.

The prevention of abuse and fatal abuse includes sufficient mental health services and support for the parents, which should be offered without delay. The signs of battering may be detected in daycare, by health care nurses and relatives and prompt interventions are needed since the battering may relapse quickly.

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